# Utah Health Information Technology Strategic Plan 2016-2020

## GOAL 2: STRENGTHEN HEALTH CARE DELIVERY TRANSFORMATION

**OBJECTIVES:**

**2A**. Increase HIT functions to support transparency of and access to quality and cost information at the community and provider level to improve care

**2B.** Increase implementation of HIT functions to support innovative models of care that promote high-value health care – Medical Home, ACOs, Telehealth

**2C.** Increase use of electronic quality improvement tools and measurements that support provider adherence to evidence-based guidelines, improved outcomes and reduced waste

**2D.** Support the use of health IT to help providers and communities to better serve high-risk individuals and populations

**PROJECTS (STRATEGIES)**

**2.01 Provider Support for Quality Reporting (PQRS, MU, MACRA)**

**Action: Implementation Primary: HealthInsight and UHIN**

HealthInsight gives quality improvement support to Utah physician offices and hospitals on reporting and improving quality measures. Specific emphasis on the Quality Payment Program (QPP), Accountable Care Organizations (ACOs), other Alternative Payment Models (APMs), behavioral health care and Ambulatory Surgical Center care are a focus for improvement efforts and improving outcomes. UHIN is working with providers to meeting Meaningful Use requirements and assist with criteria for QPP and is evaluating whether to assist members with reporting.

**2.02 EHR Guide for Quality Reporting**

**Action: Implementation Primary: UDOH-EPICC, HealthInsight**

Quality Data for Beginners: Using your Electronic Medical Record for Quality Reporting and Better Patient Care has been updated in 2017 to encompass cardiac measures and provides guidance for success in quality reporting for primary care practices. *(Subcontract to HealthInsight, under UDOH CDC 1422 funding*

**2.03 GetHealthyUtah.org (Population Health)**

**Action: Implementation Primary: Utah Leaders for Health**

To improve the health of all Utahns by supporting healthy eating and active living in order to associated health consequences.

**2.04 Death Notifications**

**Action: Expansion Primary: UDOH**

To develop timely notifications of deceased patients or members to providers and payers for them to improve their population health data.

**2.05 Long-Term/Post-Acute Care Summary Exchange**

**Action: Expansion Primary: UHIN**

This is an ONC project intended to exchange CCD documents between hospital and long term care providers. The pilot effort included Avalon and Intermountain Healthcare. The expansion effort is to include all LTCs and Hospitals.

**2.06 Dashboards (HIT, NQF, Monarch) for Geographic Quality Analysis**

**Action: Expansion Primary: UHIN**

This project intends to provide hot spotting to providers for their patient panels and for public health reporting. There are currently 36 measures contained in the system.

**2.07 Adult Immunizations - increase rates (flu, pneumonia)**

**Action: Implementation** **Primary: HealthInsight, UDOH-USIIS**

Working with organizations to help improve the assessment and documentation of Medicare beneficiaries' immunization status, increase overall immunization rates and reduce immunization disparities.

**2.08 HealthInsight's Quality Awards Program**

**Action: Expansion** **Primary: HealthInsight**

The HealthInsight Quality Award Program was launched in 2004 to promote high quality and transparency in health care. Yearly awards are given to Utah health care provider organizations based on standardized criteria (including Health IT) in the following areas:

- Home Health
- Hospital
- Nursing Home
- Physician Office

**2.09 ADT Alerts for reducing admissions and readmission**

**Action: Expansion** **Primary: UHIN**

Encounter Notification Services for the community and pushing those to different endpoints to rural and out of state providers.

**2.10 Clinical information exchange among public health, EHRs, and HIE**

**Action: Expansion** **Primary: UDOH-DCP, UHIN**

To expand clinical data exchanges between HIE, EHRs and public health programs to support population health improvements (Baseline on operational use cases = 3, Immunization, EHR, and Syndromic Surveillance). Expanding to Newborn Screening and planning for cancer registry.

**2.11 Obesity & Diabetes Population Health**

**Action: Planning** **Primary: UDOH, UHIN**

Baseline measures of obesity and diabetes using clinical data stream are obtained from the CHIE.

**2.12 Behavioral Health & Primary Care Interoperability**

**Action: Planning** **Primary: UDOH, UHIN**

Assessment of best use of interoperability between behavioral health and primary care

**2.13 Utah Regional Health Care Innovation Day**

**Action: COMPLETED** **Primary: HealthInsight**

The Utah Regional Health Care Innovation Day brings together health care professionals, payers, health care organizations, and state and federal government officials to discuss innovations to transform health care. During this event those working locally to improve health, provide care and lower costs through innovative strategies will share their vision, lessons learned and results. A one day planning session was held.

**2.14 Indian Health Geographic Analysis**

**Action: Planning** **Primary: UDOH, UHIN**

A state wide assessment of Indian health status using multiple state data bases for 3 use cases of Behavioral Health, Obesity Diabetes reduction, and End of Life care.

**2.15 COB Database - Payer coordination**

**Action: Implementation** **Primary: UHIN**

Working with community payers to improve the Coordination of Benefits.

**2.16 Statewide PCORnet Collaboration for Reducing Uncontrolled Hypertension**

**Action: Planning Primary: UDOH, UHIN, Intermountain, University of Utah**

UDOH collaborates with the Intermountain and the University of Utah's academic clinical databases ("PCORnet" Projects) to assist UHIN to develop a PCORnet compatible database and enable clinical information exchange among the three PCORnet's nodes. Initial clinical information to be exchanged is related to hypertension and hypertension-related diseases. This initiative is to support the Utah Governor's Legacy Project to reduce uncontrolled hypertension in Utah.

**2.17 Fall Prevention Initiative**

**Action: Planning Primary: UDOH, UHIN**

This initiative is based on legislative interest. It is to explore using EMS data to identify and alert providers/Aging Services on patients with the potential for falls so that they can follow up. This project also entails exploring ability to share information with social services agencies.

**2.18 Shared Care Plan**

**Action: Planning Primary: UDOH, UHIN, UHPP**

This project is to enable sharing of care plans across disparate providers to enhance care coordination. This includes behavioral health care plans and referrals for vulnerable populations.

**2.19 Home Health Hub**

**Action: Planning Primary: UDOH, UHIN**

Using HIT for Home Health Orders to increase timeliness of care. Would allow for electronic signatures on orders. A design meeting has been held.

**2.20 Social Service Referrals – Addressing social determinants in healthcare**

**Action: Planning Primary: UDOH, UHIN, United Way**

Have assessments in primary care and developing the ability of primary care to refer to 211 and then having the referral report back to the provider through the CHIE.

**2.21 Pharmacy integration medication reconciliation**

**Action: Planning Primary: UHIN, HealthInsight**

Integrating pharmacy data into the CHIE for medication reconciliation of non-controlled substance medication. This is related to the Cancel RX initiative.

| Goal 2: Strengthen Health Care Delivery Transformation | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Measures** | **No.** | **Indicator** | **Responsible Organization** | **Baseline 12/31/2016** | **12/2017** | **3/2018** | **Current 9/2018** | **2018 Goal** | **Status from Last Report** | |
| 2.1. Integrating exchange of information in care delivery workflow | 2.1.1 | # of clinical entities receiving cHIE ADT alerts | UHIN | n/a | 96 | 96 | 97 | Increase | Increased | ★ |
| | 2.1.2 | # of payers receiving cHIE ADT alerts | UHIN | n/a | 7 | 7 | 8 | Increase | Increased | ★ |
| | 2.1.3 | # of behavior health practices receiving cHIE ADT alerts | UHIN | n/a | 3 | 3 | 5 | Increase | Increased | ★ |
| 2.2. Participation in alternative payment and delivery models | 2.2.1a | # of CMS ACOs | HealthInsight | n/a | 5 | 5 | 5 | Increase | No change | |
| | 2.2.1b | # of entities in federal Alternative Payment Models | HealthInsight | n/a | 23 | 25 | 13 | Increase | Decreased | |
| | 2.2.2 | # of practices recognized as meeting Medical Home requirements for care management information exchange | HealthInsight | n/a | 50 | 109 | 123 | Increase | Increased | ★ |